

CODING COMPLIANCE: BEYOND THE CODES

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The Public is Watching

HealthGrades. Office of Inspector General. RAC. These are just a few of the eyes and ears of healthcare. Like a news reporter in search of a story, these industry watchdogs and others like them are peering over shoulders to uncover signs of poor patient care and fraudulent billing. Coded data is often the main resource for their stories and lies at the center of their investigations.

Clinical coders, physicians and health information management (HIM) directors must comply with their demands and endure their scrutiny. Everyone is caught in a constant struggle to balance greater productivity and faster reimbursement with data accuracy and regulatory compliance. It's a tough job and now the public is watching!

To cope, most organizations have implemented coding compliance plans along with an organization-wide clinical documentation improvement (CDI) programs. These programs work together to reduce external investigations and minimize risk. This article explores the most important steps in developing a coding compliance program and provides practical tips for partnering with clinicians to improve clinical documentation and data accuracy.

Audits Improve Accuracy, Serve as Cornerstone for Compliance

The old adage “what gets measured, gets done” has never been more true—or more relevant. Now more than ever, coded data is under the microscope and all governance is focused on accuracy. A recent survey of HealthPort customers reports a dramatic uptick in coding audits not only from RACs, but from other external agencies as well.

Organizations can reduce the risk of compliance audits by successfully conducting internal ones. The [American Health Information Management Association \(AHIMA\)](#) provides a wealth of resources on establishing internal coding audit programs and recommends hiring an external auditor at least once a year—and more often if possible. An outside review helps strengthen future internal audits by discovering how and why internal audits may have overlooked findings. Furthermore, by conducting numerous, smaller audits organizations receive a number of valuable benefits.

Audits provide immediate validation of education received from the previous audit. When conducted on a routine basis, organizations gain a leg-up on liability mitigation—frequent reviews catch problems sooner and allow for claims resubmission more easily than once-a-year audits. Finally, more frequent coding audits provide better data for strategic and financial planning which gives executives better insight for service line expansion and competitive positioning.

In the July issue of the [Journal of AHIMA](#), HealthPort experts Cathy Brownfield, RHIA, CCS and Donna Didier, Med, RHIA, CCS, lay out the three phases of an external coding audit: preparing for the audit; managing the audit; and reviewing and implementing recommendations. Authors mention external coding audits should not be finger-pointing sessions for coders or result in a stack of useless binders. To be successful, external coding audits must be part of the overall compliance program and positioned as educational feedback. The end result should be concrete, meaningful recommendations alongside lasting change.

While AHIMA recommends a minimum of one per year, many organizations find that numerous smaller audits provide additional benefits.

Compliance Programs: All Aboard!

All coders must participate in the coding compliance plan—no exceptions. Accuracy must be defined at the code level, not just the DRG level and should be measured not only for those items coded, but also those missed (e.g. mentioned in the clinical documentation, but not coded by the coder).

If using external coding resources, ask for compliance scores, credentials, and a sampling of coding services. Outsourcing agencies are eager to earn your business. By coding a limited number of charts, the agency gains a better understanding of your clinicians' documentation patterns along with your specific preferences. In return, you get a relevant sample of coding accuracy and can evaluate whether a higher quality coding is worth the additional investment. The extra cost for high quality coding can pay tremendous dividends in better quality scores, fewer investigations, and recouped revenues.

Finally, HIM Directors can improve their chances of high compliance levels by focusing coders on those cases where they have experience or express a desire to learn. We recommend that clients conduct a coder inventory of skills to know the unique strengths and weaknesses of each coder and make assignments accordingly. From there, the use of advanced coding tools and technology is highly recommended.

The essence of successful coding compliance is accuracy. Compliance programs force everyone to spend more time doing their jobs; therefore you must help them be as productive as possible. Giving them the proper tools and correct work assignments is a good first step, improving clinical documentation is the next.

Clinical Documentation Joined at the Hip

There is no way to demonstrate coding accuracy without solid, complete clinical documentation. The relationship between the two is undeniable. However, with everyone pushed to be more productive and do more with less resources, the additional time coder and clinicians need to improve clinical documentation is in scarce supply. Coders don't have time to continually query physicians and request clarification. Physicians don't have time to respond.

To alleviate these concerns and improve coded data, most organizations have implemented some form of a clinical documentation improvement (CDI) program. These programs should encompass all the various compliance demands, not just coding. The program should encourage greater communication between coders and physicians while also focusing on granularity and specificity of clinical documentation.

Dr. William Walker, MD, FACP, CCS, CHC, is a leading advocate for CDI programs and suggest greater partnerships between coders, HIM directors and the medical

Coding Compliance Plans: A Checklist for Success

Time Frame	Recommendation
Initial Review: A coder's first week	100% of work is reviewed. 95% accuracy must be met
Ongoing Review: Work reviewed every week	2% of a coder's cases are reviewed every week. 95% accuracy must be met.



staff. To get physicians on board he shares these three basic truths:

- Most physicians were never taught the importance of clinical documentation.
- Communication is not a core competency for most medical staff.
- Physician quality scores are created and driven directly from codes—and physicians care about quality scores!

Dr. Walker recommends that coders and HIM directors keep these truths in mind when talking with physicians about clinical documentation. Additionally, he suggests the use of real case examples of poor clinical documentation along with the revenue lost. Finally, time is always of the essence for physicians. A quick comparison of incomplete documentation and the number of physician queries associated will deliver a strong message: document during the encounter and you'll have less paperwork afterwards.

Conclusion

The recent barrage of requests for coded data will continue to intensify as tighter controls and greater public awareness are placed on healthcare quality. Since clinical codes serve as the foundation for much of this data, it only makes sense to carefully analyze coding accuracy—now and for the future. By implementing and maintaining coding compliance and CDI programs, organizations can reduce the number of outside investigations—and better manage the reporters when they call!